THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-0211.M5

MDR Tracking Number: M5-04-2465-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 04-07-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The IRO reviewed office visits (with and without manipulation), joint mobilization, myofascial release, therapeutic exercises, manual therapy techniques, and neuromuscular re-education services rendered from 4/10/03 to 11/03/03 that were denied based upon "U".

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The following services and dates of service **were found** to be medically necessary.

- CPT code 99211MP: Level I office visit with manipulation on 4/10/03, 4/24/03, 5/30/03, 8/11/03, and 8/26/03.
- CPT code 97265: joint mobilization on 6/24/03 through 7/31/03
- CPT code 97110: therapeutic exercises on 5/12/03, 5/13/03, 5/20/03, 5/22/03, 5/28/03, 5/30/03, 6/03/03, 8/11/03, 8/12/03, 8/21/03, 8/25/03, 8/26/03, 8/28/03, 9/03/03, 9/5/03, 9/8/03, 9/9/03, 9/11/03. 9/17/03. 9/25/03, 9/30/03, 10/02/03, 10/6/03, 10/7/03, 10/9/03, 10/16/03, 10/27/03, 10/28/03, 11/3/03.
- CPT code 99213: Level III office visit without manipulation on 4/17/03, 5/8/03, and 5/12/03
- CPT code 99213MP: Level III office visit with manipulation on 5/1/03, 5/20/03, 5/22/03, 5/28/03, 6/3/03.
- CPT code 99211: Level I office visit without manipulation on 8/25/03, 8/28/03, 9/5/03, 9/8/03, 9/11/03, 9/30/03, 10/2/03, 10/6/03, 10/7/03, 10/9/03, 10/27/03, 10/28/03, 11/3/03.

- CPT code 97112-59: neuromuscular re-education on 10/2/03, 10/7/03, and 10/9/03.

The office visits on 7/24/03; 7/25/03, 7/31/03, 8/1/03, 8/6/03 and 8/8/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 5th day of May 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 7/08/03 through 10/31/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 5th day of May 2004.

David R. Martinez, Manager
Medical Dispute Resolution
Medical Review Division
DRM/rlc

September 7, 2006

MDR Tracking #: M5-04-2465-01
IRO #: 5284

___has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

This case was reviewed by a licensed chiropractor with a specialty in chiropractic. The ___health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient fell from a platform on ___ causing him to fracture his ankle. He had a surgical procedure on 4/24/02. He underwent multiple modalities of treatment with ___. ___ pursued treatment with the patient until and after the patient had a second surgical procedure on 6/5/03 by ___. Active therapy protocols were performed until 10/27/2003.

DISPUTED SERVICES

Disputed services included 99211-OV, 99211-MP (OV with manipulation), 99213-)V, 99213-MP OV with manipulation, 97265 joint mobilization, 97250 myofascial release, 97110 Therapeutic Exercise, 97140-59 manual therapy tech, 97112-59 neuromuscular re-education as denied by carrier for medical necessity with "V" codes. (Do not review OV on 8/11/03). Dates of service range from 4/10/03 through 10/27/03.

DECISION

The reviewer agrees with the previous adverse determination for the following services: **99211MP** (4/29, 5/13); **97140-59** (8/11, 8/12, 5/21, 8/25, 8/26, 8/28, 9/3, 9/5, 9/8, 9/9, 9/11, 9/25, 9/30, 10/6, 10/27 These dates of service were denied due to poor documentation of the therapy that was billed); **97265** (4/10, 4/14, 4/17, 4/21, 4/22, 4/24, 4/29, 5/1, 5/5, 5/8, 5/12, 5/13, 5/20, 5/22, 5/30); **97250** (4/10, 4/14, 4/17, 4/21, 4/22, 4/24, 4/29, 5/1, 5/5, 5/12, 5/13, 5/22 5/30); **97110** (4/10, 4/14, 4/17, 4/21, 4/22, 4/24, 4/29, 5/1, 5/5, 5/8); **99213** (4/14, 4/21, 4/22, 5/5); **99213-MP** (4/29); All of the services above should be considered not medically necessary.

The reviewer disagrees with the previous adverse determination for the following services: **99211MP** (4/10, 4/24, 5/30, 8/11, 8/26); **97265** 6/24, 6/30, 7/2, 7/10, 7/15, 7/17, 7/21, 7/22, 7/24, 7/29, 7/31); **97110** 5/12, 5/13, 5/20, 5/22, 5/28, 5/30, 6/3, 8/11, 8/12, 8/21, 8/25, 8/26, 8/28, 9/3, 9/5, 9/8, 9/9, 9/11, 9/17, 9/25, 9/30, 10/2, 10/6, 10/7, 10/9,10/16, 10/27, 10/28 and 11/3/03). (The last two dates are not in the parameters set by TWCC; however, they are on the table of disputed services as sent by TWCC. If these services were not to be reviewed they should be disregarded). **99213** (4/17, 5/8, 5/12); **99213 MP** (5/1, 5/20, 5/22, 5/28,6/3); **99211** (8/25, 8/28,9/5,9/8, 9/11, 9/30,10/2, 10/6, 10/7, 10/9, 10/27 10/28, 11/3); **97112-59** (10/2, 10/7, 10/9). All of the services in this paragraph should be considered medically necessary.

BASIS FOR THE DECISION

The reviewer indicates that the patient required both pre and post-surgical rehabilitation of approximately two weeks and eight weeks duration, respectively as per Rehabilitation of the Orthopedic Surgical Patient by ___. Secondly, the ACOEM Guidelines indicate that the services were necessary. Passive therapy at any point of time was unnecessary. The only exception to this was the joint mobilization to increase ankle ROM immediately following surgery. Other guidelines utilized include the TX Guidelines for Chiropractic Quality Assurance and Practice Parameters and Evidence Based Medical Guidelines.

___has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Sincerely,